

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03803

03793

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN IT <u>50 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brown Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>704 S. Washington</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Emma King Atkinson</u>		<b>4. DATE OF DEATH</b> 3/13/66 Month Day Year		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/15/1895</u>		<b>9. AGE</b> (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Castle Del</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>John King</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary G. Stun</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>				<b>17. INFORMANT</b> <u>289 D. Union Ave</u> <u>Unknown Mrs. Leland Fox Harford Chase, Md</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatitis, chronic</u> <u>5410</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>duodenal ulcer</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		19 <u>65</u> to <u>3/10</u> , 19 <u>66</u>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12/12</u> , 19 <u>65</u> , to <u>3/10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/12</u> , 19 <u>66</u> and that death occurred at <u>2 A.M.</u> , from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>John D. Van</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				<b>22b. DATE SIGNED</b>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN D. VAN</u>						<b>22d. ADDRESS</b> <u>HARFORD GRAVE RD</u>									
<b>23a. (BURIAL, CREMATION, REMOVAL)</b> (Specify)				<b>23b. DATE THEREOF</b> <u>3/15/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Angel Hill</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Harford Chase Md</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Donny Van, Harford Chase, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 15 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

80708

STATION C. BATH

80908

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the main body of the page.]*

*[Faint handwritten text at the bottom left, possibly a date or signature:]*  
MAR 18 1908  
[Illegible]

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03804		03794	
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harvre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
c. LENGTH OF STAY IN 1b <u>3 1/2 days</u>		d. STREET ADDRESS <u>Rt. 2 Box 180</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First Middle Last		4. DATE OF DEATH <u>March 7</u> Month Day Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator U.S. Govt.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jan Zelenka</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7127</u>	
17. INFIRMANT <u>Charles W/ Bem, Rt. 2, Bel Air, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Congestions</u> <u>4221</u> DUE TO (b) <u>Coronary-sclerotic C-D Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>yes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1966</u> to <u>March 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1966</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Ralph J. Horkey</u>		22d. ADDRESS <u>Churchville, Harford Co., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 9, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, R.D. Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR <u>MAR 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10-01

20000

THE  
HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE  
DISTRICT OF  
ST. JOHN'S  
NEW BRUNSWICK  
CANADA

TO THE  
HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE  
DISTRICT OF  
ST. JOHN'S  
NEW BRUNSWICK  
CANADA

TO THE  
HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE  
DISTRICT OF  
ST. JOHN'S  
NEW BRUNSWICK  
CANADA

TO THE  
HONORABLE  
MEMBER OF PARLIAMENT  
FOR THE  
DISTRICT OF  
ST. JOHN'S  
NEW BRUNSWICK  
CANADA

## CERTIFICATE OF DEATH

Reg. Dist. No.

03795

03805

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa md</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Joppa md</u>	
3. NAME OF DECEASED (Type or print) <u>Jennox</u> First <u>Burchett</u> Middle <u>Bond</u> Last		4. DATE OF DEATH <u>Mar</u> Month <u>13</u> Day <u>1966</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 17, 1982</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Fallston Hfd Co md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jennox B Bond</u>		14. MOTHER'S MAIDEN NAME <u>Anna Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Edwin Bond Joppa md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Cardiovas. Dis</u> DUE TO (c) <u>General Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>7 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-25</u> , 19 <u>62</u> to <u>3-13</u> , 19 <u>66</u> and that death occurred at <u>9:50</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>FORK, MD</u> DATE SIGNED	
ACTUAL SIGNATURE <u>Clifford F. Hudson</u>		PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 16, 1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Friendship Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Fallston md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer</u>		ADDRESS <u>Benson, md</u>	
24a. REC'D BY REGISTRAR <u>MAR 16 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

IN SENATE,  
January 15, 1890.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN ANSWER TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1889.  
ALBANY:  
J. B. LIPPINCOTT & CO.,  
PRINTERS.  
1890.



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03806

03796

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u>				c. LENGTH OF STAY IN lb <u>3 1/2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hosp.</u>				d. STREET ADDRESS <u>Cresswell &amp; Goat Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>Nichols</u> Last <u>BRANSON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 4, 1896</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Medical Supplies</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Haven Co. Waterbury, Conn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles Pardee BRANSON</u>				14. MOTHER'S MAIDEN NAME <u>GRACE Nichols</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>283-124701</u>		17. INFORMANT <u>Mrs. Grace T. Bronson, Bel Air R.D.#2, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 4221 DUE TO <u>Chronic Card</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S. C.V.D. Class IV, D</u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1963</u> to <u>3/1</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>MARCH 1 1966</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo</u>				22b. DATE SIGNED <u>3/1/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>	
22d. ADDRESS <u>Hause de Grace, Md.</u>				22e. ADDRESS <u>Hause de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>				25a. REC'D BY REGISTRAR <u>MAR 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2850

10



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03807

03797

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HARFORD MEMORIAL HOSPITAL		d. STREET ADDRESS 23 Monroe Street	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIE D. BUFORD		4. DATE OF DEATH Month Day Year 3 14 1966	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-20
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		9b. KIND OF BUSINESS OR INDUSTRY Lumber yard	9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour		10b. KIND OF BUSINESS OR INDUSTRY Lumber yard	11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Evie Buford	
14. MOTHER'S MAIDEN NAME Ada Massey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII	
16. SOCIAL SECURITY NO. 421-01-8378		17. INFORMANT Mrs. Florette Buford, Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carbon monoxide poisoning DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute alcoholic intoxication (0.26%)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Dragged from burning smoke-filled home		20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:41 PM 3-14-1966	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Aberdeen		20g. (County) Harford	
20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Russell S. Fisher		22. DATE SIGNED 3-14-66	
EXAMINER'S NAME (Type) RUSSELL S. FISHER, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 3-18-66	23c. NAME OF CEMETERY OR CREMATORY Airmount Cemetery	23d. LOCATION (City, town or county) (State) Thomasville, Ala.
24. FUNERAL DIRECTOR Otis J. Bullock, Havre de Grace, Md.		25a. REC'D BY REGISTRAR MAR 18 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03808

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03798

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2' 10"</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>916 Holland Road</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK JAMES CLARK</u>		4. DATE OF DEATH <u>March 7 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 3, 1909</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store Owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Trenton, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy J. Clark, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Conannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>153-01-4868</u>	
17. INFORMANT (Name) <u>Mrs. Gertrude I. Clark</u>		Address <u>916 Holland Road, Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior myocardial infarction</u> <u>1901</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>A.S. C.V.D.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1966</u> , to <u>March 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 7, 1966</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo</u>		22b. DATE SIGNED <u>3/7/66</u>	22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 9, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cemetery</u>
23d. LOCATION (City, town or county) (State) <u>Hickory, Hartford Co., Maryland</u>		24. FUNERAL DIRECTOR <u>Joseph William Foster</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
25c. DATE <u>MAR 9 1966</u>		25d. ADDRESS <u>W. Broadway &amp; Williams, Bel Air, Maryland 21014</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03803 CERTIFICATE OF DEATH 03799											
1. PLACE OF DEATH a. COUNTY <u>Harford Co</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>1-28-3-14</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BREVIN Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>2. W. Churchville Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Sadie Emma Cloman</u> First Middle Last						4. DATE OF DEATH <u>March 14, 1966</u> Month Day Year					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-14-86</u> yrs. Months Days		9. AGE (In years last birthday) <u>80</u> IF UNDER 1 YEAR IF UNDER 24 HRS.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Swift</u>						14. MOTHER'S MAIDEN NAME <u>Jerry Baldwin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>212-05-0703</u>		17. INFORMANT <u>Mrs. Roberta Catron</u> Address <u>VERMONT PLACE BEL AIR, Maryland 21014</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C of heart with metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-16, 1966</u> to <u>3-14, 1966</u> that (I) (we) last saw the deceased alive on <u>3-10, 1966</u> , and that death occurred at <u>2:27 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Guenter J. Hirsch</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Guenter J. Hirsch, M.D.</u>						22d. ADDRESS <u>131 S. Union Ave., Harford Green, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>March 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Fountain Green, Harford Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAR 17 1966</u>											

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3-14-50



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

FOR STATE  
HEALTH DEPT.



03810

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03800

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b> d. STREET ADDRESS <b>Box 118, RD #3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>KEITH</b> Last <b>COLDIRON</b>		4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1964</b>
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>Larry Toliver</b>		15. MOTHER'S MAIDEN NAME <b>Betty E. Toliver Coldiron</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>—</b>	
18. INFORMANT (Mother) <b>Betty E. Coldiron</b>		19. ADDRESS <b>Box #3, Box #118 BEL Air Maryland 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute interstitial pneumonitis</b> 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		22. DATE SIGNED <b>3/31/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 2, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>BEL Air Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>BEL Air Harford Co. Md. 21014</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		25a. REG. NO. <b>1956</b>	
25b. ADDRESS <b>W. Broadway &amp; Williams St. BEL Air, Maryland 21014</b>		25c. SIGNATURE <b>Joseph William Foster</b>	

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>													
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">03811</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> <span style="float: right;">03801</span> b. COUNTY <u>Harford</u>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. LENGTH OF STAY IN 1b <u>33 days</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shoppa</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>714 Philadelphia Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>FRANK</u>				First <u>Joseph</u> Middle <u>COPSEY</u> Last <u>COPSEY</u>				<b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>6</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-28-96</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Filling Station Operator</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Gasoline</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN Wm COPSEY</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Susie Thompson</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>216-18-9440</u>		<b>17. INFORMANT</b> <u>Barbara Copsey (wife) same as above</u> Address <u>same as above</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema, acute</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCD</u> DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 hours</u> <u>?</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>Persistent Hemorrhage post cholecystectomy 12 days</u>													
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/9</u> , 19 <u>66</u> , <b>to</b> <u>3/6/66</u> , 19 <u>  </u> , <b>that (I) (we) last saw the deceased alive on</b> <u>3/6/66</u> , 19 <u>  </u> , <b>and that death occurred at</b> <u>7:30</u> M, <b>from the causes and on the date stated above.</b>													
<b>22a. SIGNATURE</b> <u>AW Grigoleit</u>												<b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME</b> <u>AW GRIGOLEIT</u>												<b>22d. ADDRESS</b> <u>HARRE De Grace, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>Mar. 9, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cokesbury Memorial Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Abingdon Harford Md</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Howard K. McComas &amp; Son</u>						<b>ADDRESS</b> <u>Abingdon, Md. 21009</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAR 9 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

10350

0301



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03812 CERTIFICATE OF DEATH 03802

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hartford-de-Grace</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hartford Memorial Hospital</i>		e. STREET ADDRESS <i>12-1 St. Box 15 Jay Lora Rd</i>	
3. NAME OF DECEASED (Type or print) <i>George Philip Coser</i>		4. DATE OF DEATH <i>3 4 19 66</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 25, 1923</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>ELECTRIC WELDER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SHIPBUILDING</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Louisiana</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Coser, George</i>		14. MOTHER'S MAIDEN NAME <i>Philips, Estelle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>429-24-5784</i>	
17. INFORMANT <i>MYRTLE R. COSER, STREET, MD.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dissecting aortic aneurysms</i> <i>451X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>A.S.C.D.</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 day 4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension + Chronic Pyelonephritis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY-MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3/2</i> , 19 <i>66</i> to <i>3/4</i> , 19 <i>66</i> that (I) (we) last saw the deceased alive on <i>3/4</i> , 19 <i>66</i> , and that death occurred at <i>7</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward C. Loo, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>3/4/66</i>
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22d. ADDRESS <i>Hartford-de-Grace, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>MAR. 7, 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MEADOWBROOK MEMORIAL</i>	23d. LOCATION (City, town or county) (State) <i>ELKBRIDGE, MD.</i>
24. FUNERAL DIRECTOR <i>John H. Hookins, DELTA, PA.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03813

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03803

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>127 Stokes Street</b>		d. STREET ADDRESS <b>127 Stokes Street</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>ELEANOR</b> Last <b>CRESMER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>7/26/1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Leads</b>	9. AGE (In years lost birthday) <b>58</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Burtram T. Spink</b>		14. MOTHER'S MAIDEN NAME <b>Ana D. Poplar</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unborn</b>	
17. INFORMANT <b>Beverly Callum Harford Co. Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Subarachnoid Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rupture of Aneurysm of Right Middle Cerebral Artery.</b> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.		22. DATE SIGNED <b>3/22/66</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		Address (Street, city, town, or county)	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>3/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Aldino, Md.</b>
24. FUNERAL DIRECTOR <b>Burroughs Co. Harford Co. Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE de Grace</b> c. LENGTH OF STAY in 1b <b>2 hr. 30 min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HARFORD Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE de Grace</b> d. STREET ADDRESS <b>RD #1 Box 177</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Deckman</b> 4. DATE OF DEATH <b>MARCH 11 1966</b>		5. SEX <b>MALE</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>3-11-66</b> 9. AGE (In years last birthday) <b>2</b> yrs. <b>30</b> Months <b>11</b> Days <b>30</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) <b>HARFORD Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>MARVIN DECKMAN</b>		14. MOTHER'S MAIDEN NAME <b>BETTY SHIPLEY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MARVIN DECKMAN</b> Address <b>RD #1 Box 177</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Baby not sufficiently developed</b> <b>776X</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3-11</b> , 1966, to <b>3-11</b> , 1966, that (I) (we) last saw the deceased alive on <b>MARCH 11</b> 1966, and that death occurred at <b>2:30 PM</b> from the causes and on the date stated above.		
22a. SIGNATURE <b>GUNTHER D. HIRSCH</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3-11-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>GUNTHER D. HIRSCH</b>		22d. ADDRESS <b>1315 UNION AV. HAVRE DE GRACE, MD.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANGEL HILL</b>		23d. LOCATION (City, town or county) (State) <b>HAVRE DE GRACE, MD.</b>				
24. FUNERAL DIRECTOR <b>Bennington + Son</b>		ADDRESS <b>Havre de Grace</b>		25a. REC'D BY REGISTRAR <b>MAR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN b <u>35 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>116 Beaver</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Joshua G. Fisher</u>						4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 17-1896</u>		9. AGE (In Years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Andrew Fisher</u>						14. MOTHER'S MAIDEN NAME <u>Hanna Baldwin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unk.</u>						16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Mary C. Fisher</u> Address <u>116 Beaver St. Harford Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>generalized arteriosclerosis</u> (c) <u>Coroner of Rt. Kidney</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>6 months</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour <u>e.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>66</u> to <u>March 8</u> 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>March 8</u> 19 <u>66</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>E. J. Simon</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/9/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>						22d. ADDRESS <u>Harford Del. Grove</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Park</u>		23d. LOCATION (City, town or county) <u>Udinto Md.</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donny L. Simon</u>						ADDRESS <u>Harford Del. Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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STATE OF OHIO

MAR 12 1866

Wm. H. Johnson



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 206 & 21 Film G375 4/6/66  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03816 CERTIFICATE OF DEATH 03806

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen PG,		c. LENGTH OF STAY IN 1b N/A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS C Btry, 4th Msl Bn, 1st Arty	
3. NAME OF DECEASED (Type or print) First ELTON Middle L. Last FOYE		4. DATE OF DEATH Month March Day 27 Year 19 66	
5. SEX Male	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 May 1945
9. AGE (In years last birthday) 20 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier	
11. BIRTHPLACE (County & State, or foreign country) Johnson Co, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Foye		14. MOTHER'S MAIDEN NAME Annie Ruth Atkinson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Sep 65 27 Mar 66		16. SOCIAL SECURITY NO. 237-70-8701	
17. INFORMANT Service and Health Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Chest 9197 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 35 Mins
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gunshot - Undetermined			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour 145 p.m. Month, Day, Year Mar 27 19 66	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Guard House	20f. (City or town) (County) (State) Edgewood, Harford, Md.
21. I certify that (I) this hospital attended the deceased from 27 Mar, 19 66 to 27 Mar, 19 66, that (II) we last saw the deceased alive on DOA 27 Mar, 19 66, and that death occurred at 2200 PM, from the causes and on the date stated above.			
22a. SIGNATURE Robert P. Steinfeld		22b. DATE SIGNED 28 March 1966	
22c. PHYSICIAN'S NAME (Type) ROBERT P. STEINFELD, Capt, MC		22d. ADDRESS Kirk AH, Aberdeen PG, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Mar. 30, 1966	23c. NAME OF CEMETERY OR CREMATORY Smithfield, N.C.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR W. B. Pugh, Jr., Purgville, Md.		25a. REC'D BY REGISTRAR MAR 31 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

1 (M)

03817

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03807

1. PLACE OF DEATH a. COUNTRY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>RD 1 Box 35 Bush Chapel Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Washington Grinage</u>		4. DATE OF DEATH <u>March 25 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Mar. 1880</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bldg. Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto-Garage</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wesley Grinage</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-4973</u>	
17. INFORMANT <u>Mabel Lee Grinage</u>		Address <u>same as 2 c&amp;d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVI</u> 331X DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1966</u> to <u>March 25 1966</u> , that (I) (we) last saw the deceased alive on <u>March 25 1966</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>GUNTHER D. HIRSCH</u>		22b. DATE SIGNED <u>3-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u>		22d. ADDRESS <u>Havre de Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 Mar. 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Aberdeen, Maryland</u>	
24. FUNERAL DIRECTOR <u>Walter Macouh Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 29 1966</u>	

MEDICAL CERTIFICATION

03803

OFFICE OF DEATH

03811

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1100

Harold Memorial Hall Box 33 Chicago Ill

Charles Washington Group

State Navy

March 22 1942

March 22 1942

March 22 1942

March 22 1942

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03818

03808

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>				c. LENGTH OF STAY IN ID <u>instant</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>US Route 40</u>				d. STREET ADDRESS <u>2314 Rosewood Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Suzanne Elizabeth Guilbault</u>				4. DATE OF DEATH <u>March 12 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 10, 1963</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George G. Guilbault</u>				14. MOTHER'S MAIDEN NAME <u>Palma M. Covington</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Edgewood, Md.</u> <u>Mrs. Palma M. Guilbault, 2314 Rosewood Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>8254</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>11:30 a.m. 3-12-66</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>	
20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>MD</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bertie M</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer - M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>3-22-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Mar. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Leitz-Egan Funeral Home</u>		23d. LOCATION (City, town or county) (State) <u>New Orleans, Louisiana</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md. 21009</u>				25a. REC'D BY REGISTRAR <u>MAR 15 1966</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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RECEIVED - EXAMINER'S OFFICE OF THE

*[Faint, mostly illegible text and markings, possibly a form or document, with some handwritten notes and stamps.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03819

03809

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN DRIVE, GROUND 16 YEARS</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAVER DE GRACE 12-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>KIRK ARMY HOSPITAL</b>				d. STREET ADDRESS <b>615 CHAPEL TERRACE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALFRED LEROY HANSEN</b>			4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>1966</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>CAV</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 MAY 20 1845</b>	9. AGE (In years last birthday) <b>21</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>22</b> Hours <b>1</b> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILITARY</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MILITARY</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BLANCHARD MICH</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>THEODORE HANSEN</b>				14. MOTHER'S MAIDEN NAME <b>EBRHART, METILDA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>370-18-9478</b>		17. INFORMANT <b>MRS ALFRED L HANSEN</b> Address <b>SAME AS 2.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular occlusion</b> <b>332 X</b> DUE TO (b) <b>unknown cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. Right lower lobe pneumonia 2. Severe rheumatoid arthritis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4 March 1966</b> to <b>5 March 1966</b> , that (I) (we) last saw the deceased alive on <b>5 March 1966</b> , and that death occurred at <b>9 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Harold C. Sheaffer</b>				22b. DATE SIGNED <b>5 March 66</b>		22c. PHYSICIAN'S NAME (Type) <b>HAROLD C. SHEAFFER</b>	
22d. ADDRESS <b>KIRK ARMY HOSP, Aberdeen P.G. Md</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					
23b. DATE THEREOF <b>MAR. 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VA.</b>		24. FUNERAL DIRECTOR <b>R. Madison Mitchell</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAR 9 1966</b>		25d. ADDRESS <b>Harold Grace</b>	

MEDICAL CERTIFICATION

00281

01020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03820					03810				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <i>Harford Maryland</i>					a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harford</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harford</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford</i>					d. STREET ADDRESS <i>810 P. Union Ave.</i>				
3. NAME OF DECEASED (Type or print) <i>William T. Hollahan</i>					4. DATE OF DEATH <i>3/21/66</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7/31/1895</i>		9. AGE (In years last birthday) <i>70</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Club</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Harford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME <i>Patrick W. Hollahan</i>					14. MOTHER'S MAIDEN NAME <i>Rachel Mitchell</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>					16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Margaret Taley</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>					<i>sudden</i>				
4201 DUE TO (b) <i>Hypertensive atherosclerotic</i>					<i>3 yrs</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>cardiac</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year <i>19</i>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>43</i> to <i>3/21</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>3/21/66</i> , 19 <i>66</i> , and that death occurred at <i>7 P.M.</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>E. J. Simon</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>E. J. SIMON</i>					22d. ADDRESS <i>Harford</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>3/24/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Eun</i>		23d. LOCATION (City, town or county) (State) <i>Harford</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Charles Judge</i>					ADDRESS <i>Harford</i>		25a. REC'D BY REGISTRAR <i>MAR 28 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

018810

OFFICE OF THE DIRECTOR

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MAR 28 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03821 CERTIFICATE OF DEATH 03811											
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				c. LENGTH OF STAY IN 1b <b>47 years</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>62 East Broadway</b>						d. STREET ADDRESS <b>62 East Broadway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Henry</b> Last <b>Kehoe</b>						4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1885</b>		9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore City, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Henry Kehoe</b>						14. MOTHER'S MAIDEN NAME <b>Marie A. Gahrman</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-2949</b>		17. INFORMANT (Wife) <b>838-507362</b> Address <b>Broadway</b> <b>Mrs. Ethel M. Kehoe</b> <b>Bel Air, Md. 21014</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic CV Disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1-1</b> , 19 <b>64</b> , to <b>3-23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3-21</b> , 19 <b>66</b> , and that death occurred at <b>8P.</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>Gerald C. Palmer</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>March 24, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>						22d. ADDRESS <b>S. Main St., Bel Air, Maryland 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 26, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Met. Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Fountain Green, Harf. Co., Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>W. Broadway &amp; Williams</b> <b>Bel Air, Maryland 21014</b>						25a. REC'D BY REGISTRAR <b>MAR 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

Joseph William Foster

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03822

03812

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Convalescing Home</u>		d. STREET ADDRESS <u>118 Mansley Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Stephen M Kerr</u>		4. DATE OF DEATH <u>March 4, 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-84</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kerr</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Dady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-0320</u>	
17. INFORMANT <u>(Niece) Mrs. Helene V. Norman</u>		Address <u>Street, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture femur</u> 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic &amp; v disease</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident auto pedestrian type</u>	
20c. TIME OF INJURY Month, Day, Year <u>3 p.m. Jan. 29, 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Main Street</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 7, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Cath. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Hickory, Harf. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
<u>W. Broadway Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Department of Agriculture, Bureau of Plant Industry, Washington, D.C.

John L. ...  
(1928-29) ...

1928-29 ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> d. STREET ADDRESS <u>Box 71 - Pulaski Hwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alvin</u> Middle <u>John</u> Last <u>Klein</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1911</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Klein</u>	
14. MOTHER'S MAIDEN NAME <u>Antoinette Gerst</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>215-10-6919</u>		17. INFORMANT Address <u>Joseph Quilla, 701 Pulaski Highway, Joppa, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> <u>11 days</u> <u>  </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u>		21. I certify that (I) (this hospital) attended the deceased from <u>February 27, 1966</u> to <u>March 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>March 9, 1966</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>3/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 12, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 11 1966</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03824

03814

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen PG, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kirk Army Hospital</u>		d. STREET ADDRESS <u>122 Gordon St</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Meville</u> Last <u>Marshall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 July 1896</u>
9. AGE (In years lost birthday) yrs. <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hardford, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Crawford</u>		14. MOTHER'S MAIDEN NAME <u>Julia Van Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-46-2390</u>	
17. INFORMANT <u>Geoffrey Marshall (Son)</u>		Address <u>1412 Anniston Ave, Anniston, Ala.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>19 Yrs</u> <u>3-4 Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0.m.</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <u>10</u> (this hospital) attended the deceased from <u>5 Mar</u> , 19 <u>66</u> , to <u>7 Mar</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7 March</u> 19 <u>66</u> , and that death occurred at <u>930P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Peter Guistra</u> M.D.		22b. DATE SIGNED <u>7 March 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>PETER GUISTRA, Capt, MC</u>		22d. ADDRESS <u>Kirk Army Hospital, APG, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Episcopal Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Emmorton, Harford Co. Md.</u>
24. FUNERAL DIRECTOR <u>Robert D. Sheuman</u>		25a. REC'D BY REGISTRAR <u>MAR 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belair</u>				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>						d. STREET ADDRESS <u>RT 2; Box 217</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lulu</u> Middle <u>P.</u> Last <u>McLEAN</u>			<b>4. DATE OF DEATH</b> Month <u>MARCH</u> Day <u>19</u> Year <u>1966</u>			<b>5. SEX</b> <u>Female</u>			<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>8. DATE OF BIRTH</b> <u>29 Sep. 1892</u>			<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.			<b>IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u>		<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>			<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Grayson Co. Va.</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			<b>13. FATHER'S NAME</b> <u>Alexander Ross</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Virginia Hackler</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			<b>16. SOCIAL SECURITY NO.</b> <u>220-46-5362</u>			<b>17. INFORMANT</b> Address <u>Husband same as 2 c &amp; d</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia</u> 2044 DUE TO <u>Alcoholic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Leukemia</u> DUE TO <u>Pneumonia</u> (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 months</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)						
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>MARCH 10, 1966</u> , <b>to</b> <u>MARCH 19, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>MARCH 19, 1966</u> , <b>and that death occurred at</b> <u>4 A M</u> , <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>Dr. Henry Kwak</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			<b>22b. DATE SIGNED</b> <u>3-19-66</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. Henry Kwak</u>						<b>22d. ADDRESS</b> <u>Havre de Grace, Maryland</u>						
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>			<b>23b. DATE THEREOF</b> <u>20 Mar. 66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Burton Chapel Cemetery</u>			<b>23d. LOCATION</b> (City, town or county) (State) <u>Sugar Grove, Va.</u>				
<b>24. FUNERAL DIRECTOR</b> <u>Tarring Funeral Home, Aberdeen, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAR 22 1966</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

MEDICAL CERTIFICATION

04813

*William T. Thompson*  
*William T. Thompson*

*For 11 feet*

MAR 2 1936

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03826

03816

<b>1. PLACE OF DEATH</b> e. COUNTY <b>Harford</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Fallston</b> <span style="float: right;"><b>25 yrs.</b></span> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Charles Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Harford</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Fallston</b> <span style="float: right;"><b>12-1</b></span> d. STREET ADDRESS <b>Charles Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Nellie</b> Middle <b>Marie</b> Last <b>Miller</b>		<b>4. DATE OF DEATH</b> Month <b>March</b> Day <b>11</b> Year <b>19 66</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Feb. 16, 1897</b> <span style="float: right;"><b>69 yrs.</b></span>			
<b>9. AGE</b> (In years last birthday) <b>69</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>Thomas Mullen</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Watts</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>---</b>		<b>17. INFORMANT</b> <b>George W. Miller</b> <span style="float: right;">Address <b>21047 Fallston, Md.</b></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> years. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>none</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>none</b> e.m. <b>19</b> p.m.					
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>none</b>		<b>20f. (City or town)</b> (County) (State) <b>none</b>			
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <b>11/3, 1962</b> <b>to</b> <b>3/11, 1966</b> , that (I) (we) last saw the deceased alive on <b>3/11, 1966</b> , and that death occurred at <b>10:30 PM</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>James F. White, Jr.</b>		<b>22b. DATE SIGNED</b> <b>3/12/66</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>James F. White, Jr. M.D.</b>			
<b>22d. ADDRESS</b> <b>Jarrettsville, Maryland</b>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>					
<b>23b. DATE THEREOF</b> <b>3/15/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Bel Air Mem. Gardens</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Bel Air, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Charles E. Rutz</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAR 15 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03816

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DEPARTMENT OF HEALTH

CHIEF OF BUREAU

DEPUTY CHIEF

ASSISTANT CHIEF

UNITED STATES

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

03827

03817

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b> 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route #2,</b>		d. STREET ADDRESS <b>Route #2</b>	
3. NAME OF DECEASED (Type or print) <b>EVA</b> First <b>O.</b> Middle <b>MITCHELL</b> Last		4. DATE OF DEATH <b>March 27</b> 19 <b>66</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>16 Oct. 1884</b> 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles B. Osborn Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Jerusha Gertrude Mitchell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Jerusha Oliver,</b>		Address <b>Havre de Grace, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central vascular disease</b> 334X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.		22. DATE SIGNED <b>3-29-66</b>	
EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bel Air, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>31 Mar. 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grove Presbyterian Cemetery,</b>	23d. LOCATION (City or Town) (County) (State) <b>Aberdeen, Md.</b>
24. FUNERAL DIRECTOR <b>John B. Tarring</b>		25a. REC'D BY REGISTRAR <b>MAR 31 1966</b>	
ADDRESS <b>Tarring Funeral Home, Aberdeen, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1213

12-12-5

12-12-5



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> Harford <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Aberdeen <b>23 years</b> <b>c. LENGTH OF STAY IN 1b</b> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) none						<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) <b>a. STATE</b> Maryland <b>b. COUNTY</b> Harford <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) Aberdeen <b>d. STREET ADDRESS</b> 202 Edmund Street <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Rosella Agnes Morlok			<b>4. DATE OF DEATH</b> Month Day Year March 9 1966			<b>5. SEX</b> Female <b>6. COLOR OR RACE</b> White <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> April 21, 1878 <b>9. AGE</b> (In years last birthday) 87 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) none <b>10b. KIND OF BUSINESS OR INDUSTRY</b> - <b>11. BIRTHPLACE</b> (County & State, or foreign country) Germany <b>12. CITIZEN OF WHAT COUNTRY?</b> USA				<b>13. FATHER'S NAME</b> Adam de Martin <b>14. MOTHER'S MAIDEN NAME</b> Unknown							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) No		<b>16. SOCIAL SECURITY NO.</b> 214-12-0886		<b>17. INFORMANT</b> Miss Shirley A. Morlok, 202 Edmund St., Aberdeen, Md.							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> 4500 <i>Inanition</i> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b> (b) <i>generalized arteriosclerosis</i> (c) <i>an</i>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> 2 mos > 1 yr	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <i>arteriosclerotic heart disease</i>											
<b>2Da. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>2Dc. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19				<b>2Dd. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>2De. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> Sept 1, 1965, <b>to</b> 3-9-66 19, <b>that (I) (we) last saw the deceased alive on</b> 3-7-66 19, <b>and that death occurred at</b> 6 <sup>4</sup> AM, <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Dr. Barry J. Plunkett, Jr.</i>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> 3-9-66			
<b>22c. PHYSICIAN'S NAME (Type)</b> Dr. Barry J. Plunkett, Jr.						<b>22d. ADDRESS</b> 617 W. Bel Air Ave., Aberdeen, Md.					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial		<b>23b. DATE THEREOF</b> Mar. 12, 1966		<b>23c. NAME OF CEMETERY OR CREMATORY</b> St. Paul's Lutheran Cemetery		<b>23d. LOCATION (City, town or county)</b> Stepney Harford Md					
<b>24. FUNERAL DIRECTOR</b> Howard K. McComas & Son Abingdon, Md. 21009				<b>25a. REC'D BY REGISTRAR</b> DATE MAR 14 1966		<b>25b. REGISTRAR'S SIGNATURE</b> Charles Judge					

112818

DATE OF 1953

112818

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "DATE", "1953", and "112818" are visible.]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Bel Air (Rural) Rt 2, Box 33</u>	
3. NAME OF DECEASED (Type or print) <u>Hunter</u> First <u>Dodge</u> Middle <u>Phipps</u> Last		4. DATE OF DEATH <u>March 11, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa (Grayson Co.)</u>	
13. FATHER'S NAME <u>Roscoe Phipps, Roscoe</u>		14. MOTHER'S MAIDEN NAME <u>McCormick, Kate Delp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-18-7364</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Ventricular Failure</u> 4201 DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Q</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1964</u> , to <u>March 1966</u> , that (I) (we) last saw the deceased alive on <u>March 1966</u> , and that death occurred at <u>9:20 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Ralph Horkey</u>		22b. DATE SIGNED <u>3/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horkey, M.D.</u>		22d. ADDRESS <u>Churchville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 14, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City, town or county) (State) <u>Bel Air, Harford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

03830

03820

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE 2 whs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE 12-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>804 So. ADAMS ST</u>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Kelley</u> Last <u>Reynolds</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1886</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Kelley</u>				14. MOTHER'S MAIDEN NAME <u>FLORA FRAZER</u>			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Ruth Barkendine Haver de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Cardiac Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio-Renal Diseases</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>3-17, 1966</u> , that (I) (we) last saw the deceased alive on <u>3-17</u> , 19 <u>66</u> , and that death occurred at <u>8:40</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>A. L. Lewis, M.D.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. L. Lewis, M.D.</u>				22d. ADDRESS <u>Haver de Grace, Md.</u>			
23a. BURIAL, CREMATION, or other disposal (Specify)		23b. DATE THEREOF <u>3/20/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Siding Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Whitson, Jr., Sykesville, Md.</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03880

03880

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side. Some words like "April 1987" and "C. J. Smith" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Proving Ground</b> c. LENGTH OF STAY IN 1b <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kirk Army Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen, Maryland</b> d. STREET ADDRESS <b>53 Taft Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Selma</b> Middle <b>L.</b> Last <b>Roebuck</b>			4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>1966</b>			5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>19 Sept 1911</b>			9. AGE (In years last birthday) <b>54</b> yrs.			IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Worcester, Mass.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Unknown - [REDACTED]</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-32-4258</b>			17. INFORMANT Address <b>Peter Roebuck, 53 Taft St, Aberdeen, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>4201</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) <b>this hospital</b> attended the deceased from <b>22 March, 1966</b> , to <b>22 March, 1966</b> , that (I) <b>last</b> saw the deceased alive on <b>DOA 22 Mar 1966</b> , and that death occurred at <b>200A</b> M, from the causes and on the date stated above.													
22a. SIGNATURE <b>Arnold N. Katzoff</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>22 March 1966</b>				
22c. PHYSICIAN'S NAME (Type) <b>ARNOLD N. KATZOFF, Capt, MC</b>						22d. ADDRESS <b>Kirk Army Hospital, Aberdeen PG, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>25 Mar. 66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore, Md.</b>			23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR <b>Charles Judge</b>			ADDRESS <b>Aberdeen, Maryland</b>			25a. REC'D BY REGISTRAR <b>MAR 28 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03832 CERTIFICATE OF DEATH 03822

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		d. STREET ADDRESS <u>18 Fenway Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Beatrice</u> Last <u>Slaughter</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Feb, 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chambers Co., Ala.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry White</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ware</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*** ** *</u>	
17. INFORMANT <u>Hudman Slaughter, Aberdeen, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary accident</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on <u>MARCH 28 1966</u> , and that death occurred at <u>5:25 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gunther D. Hirsch</u>		22b. DATE SIGNED <u>3-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gunther D. Hirsch, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>30 Mar. 66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Waverly, Alabama</u>	
24. FUNERAL DIRECTOR <u>Walter Macaulay Jr.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 31 1966</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03833

03823

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen (Rural)</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route #3,</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Harford</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen (Rural)</u> d. STREET ADDRESS <u>Route #3, Box 87</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>IRENE</u> <span style="float: right;">D.</span> <span style="float: right;">SMITH</span> First Middle Last				<b>4. DATE OF DEATH</b> <u>March 27 1966</u> Month Day Year															
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4 May 1885</u> Yrs.		<b>9. AGE (in years last birthday)</b> <u>80</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>School Teacher (Ret)</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Coalton, Kentucky</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>John H. Hall</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary J. Howell</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>---</u>				<b>17. INFORMANT</b> <u>Mary F. Mink, same as 2 c &amp; d</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4200</u> DUE TO (b) <u>Constrictive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>arteriosclerotic heart disease</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>48 hrs</u> <u>34 hrs</u> <u>5 hours</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>												<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Mar 14 1962</u> <b>to</b> <u>Oct 6 1964</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Oct 6 1964</u> <b>and that death occurred at</b> <u>9:00 AM</u> <b>the causes and on the date stated above.</b>																			
<b>22a. SIGNATURE</b> <u>Barry J. Plunkett Jr.</u> <span style="float: right;">M.D.</span>												<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>3-28-66</u>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Barry J. Plunkett Jr. M.D.</u>												<b>22d. ADDRESS</b> <u>Aberdeen, Maryland</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>29 Mar. 66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft Lincoln Cemetery</u>				<b>23d. LOCATION (City, town or county)</b> <u>Washington, D.C.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter W. W. W. W.</u> <span style="float: right;">ADDRESS</span> <u>Aberdeen, Maryland</u>												<b>25a. REC'D BY REGISTRAR</b> <u>MAR 30 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAR 30 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03834					03824						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Harford			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon rural		c. LENGTH OF STAY IN 1b instant		a. STATE Maryland		b. COUNTY Harford		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN			First E.		Middle SNELLING		Last March		4. DATE OF DEATH 14 1966		
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 25, 1911		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor				10b. KIND OF BUSINESS OR INDUSTRY electrical		11. BIRTHPLACE (County & State, or foreign country) Schuylkill Pa			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Snelling					14. MOTHER'S MAIDEN NAME Annie Bowman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 162-03-6486		17. INFORMANT Catherine V. Snelling, 112 Fort Hoyle Rd. Magnolia, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1961, 19 to 1966, 19, that (I) (we) last saw the deceased alive on 3/14/66, and that death occurred at 4 P.M. from the causes and on the date stated above.											
22a. SIGNATURE E. Louis Kahan, M.D.						22b. DATE SIGNED 01/14/66					
22c. PHYSICIAN'S NAME (Type) E. Louis Kahan, M.D.						22d. ADDRESS Edgewood, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal			23b. DATE THEREOF Mar. 15, 1966		23c. NAME OF CEMETERY OR CREMATORY Geschwindt Funeral Home			23d. LOCATION (City, town or county) (State) Schuylkill Haven Pa.			
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009						25a. REC'D BY REGISTRAR MAR 16 1966		25b. REGISTRAR'S SIGNATURE g Charles Judge			

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03835

03825

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>127 N. Stokes St</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>127 N. Stokes St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Luth E. M. Stamps</u> First Middle Last		4. DATE OF DEATH <u>March 12 1966</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1899</u> 9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blind</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blind Operator</u>	11. BIRTHPLACE (State or foreign country) <u>White Top Va</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Madison N. Stamps</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Richardson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Lara B. Stamps</u> Address <u>127 N. Stokes Harford Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>976 X</u> DUE TO <u>Abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>25 W</u> DUE TO <u>Abdomen</u> (c) <u>Abdomen</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self</u>	
20c. TIME OF INJURY Month, Day, Year <u>5</u> Hour <u>3-12</u> p.m. <u>1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Harford Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		Address (Street, city, town, or county) <u>3-12-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>	23d. LOCATION (City, town or county) (State) <u>Churchville Md</u>
24. FUNERAL DIRECTOR <u>W. P. Pinnough</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		MAR 15 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEEDLE EXAMINER'S CERTIFICATE OF DATA

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "Lung", "Heart", and "Liver" are faintly visible.]*

10  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
03836  
MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
03826

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Harford Memorial Hospital</b>				d. STREET ADDRESS <b>319 S. Union Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>James Arthur Tibbs</b>				4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>19 66</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 4 - 1922</b>	9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>12</b> Days <b>1</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Churchville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Tibbs</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Johnson</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>WW 2</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Anna E. Tibbs</b>				Address <b>319 Franklin St. Havre de Grace Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive spontaneous intra-cerebral hemorrhage</b> DUE TO (b) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Werner U. Spitz</b>				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3/31/66</b>				22b. DATE THEREOF <b>3/31/66</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>				22d. LOCATION (City, town or country) (State) <b>Havre de Grace Md.</b>			
23. FUNERAL DIRECTOR <b>Franklin B. Havre de Grace Md.</b>				24a. REC'D BY REGISTRAR <b>APR 4 1966</b>			
				24b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

08280

08280

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE

TO THE HOUSE OF REPRESENTATIVES  
IN SENATE AND HOUSE OF REPRESENTATIVES  
AT WASHINGTON, D. C.  
JANUARY 1880

THE GENERAL LAND OFFICE  
WASHINGTON, D. C.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE  
FOR THE YEAR 1879

BY  
J. M. SMITH, COMMISSIONER

WASHINGTON, D. C.  
1880



1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03837

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03827

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				d. STREET ADDRESS <u>Grand Hill</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Grand Hill</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry Samuel Turner</u> First Middle Last				4. DATE OF DEATH <u>March 18</u> 19 <u>66</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 22 - 1888</u>		9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Harford County - Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Turner</u>				14. MOTHER'S MAIDEN NAME <u>Clara Lee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-20-2468A</u>		17. INFORMANT <u>Mrs. Bessie J. Scott - Harford County Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Balbir</u> 22. DATE SIGNED <u>3-18-66</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>3-18-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-23-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenview Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Level, Harford Md. Md.</u>	
24. FUNERAL DIRECTOR <u>Otelia A Bullock, Harford, Md.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



03828

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

03839

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03829

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>				c. LENGTH OF STAY IN 1b <b>5 mo.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>—</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS R. WEAVER</b>				4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>6/17/1912</b>	9. AGE (In years lost birthday) <b>53</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wash Washer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTH PLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Shuman Weaver</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hill</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WW 2</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Henry J. Weaver</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exposure to cold</b> DUE TO <b>acute ethylism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Exposure to cold while under the influence of alcohol</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3</b> p.m. <b>1</b> 19 <b>66</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beside road</b>		20f. (City or town) (County) (State) <b>Havre de Grace, Harford, Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. Breitenacker</b> M.D. EXAMINER'S NAME (Type) <b>R. Breitenacker, M.D.</b>				22. DATE SIGNED <b>3-2-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>3/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Harford, Harford, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>				25a. REC'D BY REGISTRAR <b>MAR 8 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03840

038310

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOT Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Bel Air Rd #1 Box 36</u>	
3. NAME OF DECEASED (Type or print) <u>John Edgar Webster</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/1884</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Street, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>B. Frank Webster</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Ady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>212-10-4013</u>	
17. INFORMANT <u>Mrs. Madeline Webster</u>		Address <u>RD #1 Box 36 Bel Air, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-25-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/30/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Emory</u>		23d. LOCATION (City or Town) (County) (State) <u>Street, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kutz Jarrettsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Conowingo</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>1/2 RAGAN'S GARAGE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAY</u> Middle <u>M.</u> Last <u>Whirt</u>		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1966</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27, 1925</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Fulton Twp Lane Co Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Moore</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Eisenberger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr John Ragan Conowingo Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A. due to hemorrhage.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-29, 1966</u> to <u>3-31, 1966</u> that (I) (we) last saw the deceased alive on <u>3-31 1966</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>March 31, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Lajos Mezei</u>				22d. ADDRESS <u>Havre de Grace Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 4, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Conowingo Memorial</u>	23d. LOCATION (City, town or county) (State) <u>Lancaster Pa</u>				
24. FUNERAL DIRECTOR <u>Pennington &amp; Son</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
		DATE <u>APR 4 1966</u>					

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Dr. John H. H. H.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03842

## CERTIFICATE OF DEATH

03832

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. LENGTH OF STAY IN 1b <b>5 Months</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>USA Dispensary</b>		d. STREET ADDRESS <b>2036 Battle St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Biggs</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8 Feb 62</b>
9. AGE (In years last birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Duffy Williams</b>		14. MOTHER'S MAIDEN NAME <b>Eva Biggs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>2036 Battle St, Edgewood, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>3533</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Epilepsy</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>12 Mar</b> , 19 <b>66</b> , to <b>12 Mar</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>DOA 12 Mar</b> , 19 <b>66</b> , and that death occurred on <b>0945A</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Henry N. Wagner Jr.</b>		22b. DATE SIGNED <b>12 March 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY N. WAGNER JR., M.D.</b>		22d. ADDRESS <b>USA Dispensary, Edgewood Arsenal, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-16-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St James A.M.E. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Harford, Harford, Md.</b>
24. FUNERAL DIRECTOR <b>G. Leland Bullock</b>		25a. REC'D BY REGISTRAR <b>18 MAR 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>G. Leland Bullock</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

03843

03833

1. PLACE OF DEATH a. COUNTY <u>Harford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>616 Girard ST.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H</u> Middle <u>WILSON</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10, 1891</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HRS. Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilson, Nick.</u>		14. MOTHER'S MAIDEN NAME <u>Cassie Jildon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-03-3678</u>	
17. INFORMANT <u>Mrs. Roxie W. Anthony, Harre de Grace</u>		Address <u>805 Ostroff St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-5-66</u> , 19 <u>66</u> , to <u>3-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> 19 <u>66</u> and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Norman Berger</u>		22b. DATE SIGNED <u>3/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman Berger</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>409 Union Ave. Harre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Aberdeen, Harford Co., Md.</u>
24. FUNERAL DIRECTOR <u>Othello J. Bullock, Harre de Grace, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		21078	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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